Louisiana Medicaid
Sinus Node Inhibitors

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for ivabradine (Corlanor®).

Additional Point-of-Sale edits may apply.

*These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Ivabradine (Corlanor®)

Approval Criteria

- For use in adults with worsening heart failure in a diagnosis of stable, symptomatic chronic heart failure, **ALL** of the following must apply and be stated on the request:
    - Recipient is 18 years of age or older on the date of the request**; AND**
    - Recipient has a left ventricular ejection fraction of less than or equal to 35%; **AND**
    - Recipient is in sinus rhythm; **AND**
    - Recipient has a resting heart rate of greater than or equal to 70 beats per minute; **AND**
    - **ONE** of the following**:**
        - Ivabradine is being given concomitantly with a maximally tolerated dose of a beta-blocker; **OR**
        - The recipient has a contraindication to beta-blocker use; **OR**
- For use in pediatric recipients with stable symptomatic heart failure, **ALL** of the following must apply and be stated on the request:
    - Recipient is aged 6 months or older on the date of the request; **AND**
    - Recipient is in sinus rhythm; **AND**
    - Recipient has heart failure due to dilated cardiomyopathy (DCM); **AND**
    - Recipient has a left ventricular ejection fraction of less than or equal to 45%; **AND**
    - Recipient has an elevated resting heart rate (HR); **AND**
- Ivabradine (Corlanor®) is prescribed by or in consultation with a cardiologist; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of ivabradine and will not be receiving ivabradine in combination with any medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- The provider states that the recipient is established on ivabradine (Corlanor®); **AND**
- There is documentation of a positive clinical response to ivabradine (Corlanor®) therapy.

Duration of initial and reauthorization approval: 12 months

Reference

Corlanor (ivabradine) [package insert]. Thousand Oaks, CA: Amgen Inc; April 2019. https://www.pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/corlanor/corlanor_pi.pdf

Revision / Date	**Implementation Date**
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